SENATE BILL 542
By Jackson

HOUSE BILL 1832

By Shepard

AN ACT to amend Tennessee Code Annotated, Title 68, Chapter 11 and Title 71, relative to long-term care services.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF TENNESSEE:

SECTION 1. Tennessee Code Annotated, Title 71, is amended by adding the following new chapter 7 thereto:

71-7-101. This chapter shall be known and may be cited as the "HCBS Identification and Assessment Act".

71-7- 102. The purpose of this chapter is to ensure that Tennesseans, who receive long-term care services through Medicaid, do so in the least restrictive setting appropriate in order to maximize individual autonomy, promote independence and dignity, and reduce the state's reliance upon more expensive institutional care for its seniors and persons with disabilities.

71-7-103. As used in this chapter, unless the context otherwise requires:

(1) "Bureau" means the bureau of TennCare;

(2) "Independent professional assessment" means an assessment conducted by a qualified individual who is neither an employee, agent or otherwise affiliated with an institution or other service with a financial interest in the provision of long-term care services; and

(3) "Institution" means a nursing home, developmental center, or intermediate care facility for persons with mental retardation.

71-7-104.

(a) The bureau of TennCare shall establish and maintain a comprehensive, up-to-date, central registry of all persons residing in an institution and receiving care

pursuant to Title XIX of the Social Security Act. This registry shall be in operation by July 1, 2008.

(b)

(1) The bureau shall establish a reporting system that requires institutions to report to the bureau within a reasonable period of time after the admission of a person to that institution. The consent of the person, the person's guardian, or conservator, if any, is not required.

(2) The required reports to the bureau shall be submitted on forms provided by the bureau and shall include information outlined in § 71- 7-105, as well as any other information the commissioner of finance and administration believes reasonably necessary for the assessment of an individual's long-term care needs.

(3) The furnishing of the required information shall not subject the person or institution providing the information to any liability or action for damages or relief.

(c) The bureau may discharge its responsibilities under this chapter directly, through interagency agreement, or outside contract; provided that authorized access to the records by means of a single centralized agency shall be assured.

71-7-105. To achieve the purposes of this chapter the registry shall contain information, including, but not limited to:

(1) Full name of the current or future recipient, date of birth and medical conditions, if any;

(2) Contact information of guardian or conservator, if any;

(3) Contact information of spouse and/or nearest relatives, if any;

(4) Institution of residence and length of most recent stay;

(5) Total length of stay at any and all previous institutions;

(6) Independent verification of recipient's affirmatively stated desire to either remain in an institution or transition to home and community-based services; if the recipient has a guardian or conservator with a contrary opinion then it should be noted;

(7) Independent verification regarding whether the recipient and the recipient's guardian or conservator, if any, have been fully informed of alternatives to institutional care at least once every twenty-four (24) months;

(8) Whether the recipient has applied for home- and community-based waiver services and the status of the most recent application;

(9) Enumeration of barriers - medical, financial, or otherwise - to the recipient transitioning to home- and community-based services; and

(10) Recommendations for transitioning the recipient to home- and community-based services, if desired by the recipient.

71-7-106.

(a) The bureau shall annually publish a comprehensive report by July 1 of each year utilizing the data collected pursuant to this chapter and shall submit this report with recommendations to the governor; the commissioner of finance and administration; the health and human resources committee of the house of representatives; the general welfare, health and human resources committee of the senate; the attorney general; the health services and development agency; the division of mental retardation services; and the commission on aging and disability. Furthermore, the report shall be made available to the public through the state's web site.

(b) The report shall include, but is not limited to, the following information:

(1) The number of persons receiving Medicaid services in an institution in the previous year and, of those, the number desiring to transition to home- and

community-based services. The report shall indicate how many of those desiring home- and community-based services are viable candidates for such services according to independent assessments. The report shall break down these numbers by region, age, and type of disability or medical condition;

(2) The number of recipients successfully transitioned into home- and community-based services in the previous year. The report shall break down these numbers by region, age, and type of disability or medical condition;

(3) An enumeration of the primary barriers to transition for those recipients desiring home- and community-based services, but unable to transition into home- and community-based services;

(4) A detailed breakdown and comparison of Tennessee's spending on institutional care versus home- and community-based care for persons receiving services through Medicaid; and

(5) A comparison of Tennessee's spending on institutional and home- and community-based services to spending and practices in other states.

(c) The first comprehensive report shall be due by July 1, 2008, and a progress report regarding development of the registry and assessment tools shall be due by January 1, 2008.

71-7-201. The bureau shall establish a system of independent professional assessments of all individuals living in institutions and receiving Medicaid benefits, as well as individuals seeking long-term care services through Medicaid or other state and federal programs. These assessments shall be conducted by evaluators qualified to assess and make recommendations regarding appropriate long-term care services. Furthermore, these evaluators shall be independent of any institution or provider service with a financial interest in the placement of individuals for long-term care.

71-7-202. The assessments are meant to ensure the integrity and timeliness of the information contained in the registry, as well as provide a whole-person assessment of an individual's needs, desires, and well-being for purposes of providing long-term care services in the least restrictive setting appropriate.

71-7-203. In conducting the assessments, evaluators shall personally assess, confirm, and recommend, at a minimum, the following:

(1) Whether the recipient has been properly educated regarding the recipient's options; if not the evaluator shall provide such information and connect the recipient with appropriate resources;

(2) Wishes of the recipient in regard to remaining at or receiving services in an institution; transferring to another institution; or transitioning to home- and community-based services;

(3) The complement of services and supports the recipient will need to successfully transition to home- and community-based services, making note of any needed home- and community-based services not presently offered;

(4) Barriers, medical, financial, or otherwise, to the recipient successfully transitioning to home- and community-based services; and

(5) When the next assessment should be scheduled.

71-7-204. The initial round of assessments of all recipients living in an institution shall be completed no later than July 1, 2009. Subsequent assessments shall be performed at least once every twenty-four (24) months, unless an evaluator recommends a longer interval between assessments, but in no case, shall such interval exceed thirty (30) months. In addition, a recipient has the right to request a new assessment if one has not been performed in the previous twelve (12) months.

71-7-205. If an individual expresses a desire to transition to home- and community-based services as part of the individual's assessment and if the evaluator believes such a transition may be successful, then the bureau shall take all steps necessary to begin transition within ninety (90) days, including enrollment in all appropriate Medicaid waivers and programs. In no case shall the transition take more than one hundred eighty (180) days to complete.

SECTION 2. This act shall take effect July 1, 2007, the public welfare requiring it.